STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E256	A. BUILDING _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE NORTH	1301 NE JEFFERSON ST. TOPEKA, KS 66608

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS73867, 74189.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by:	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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The facility had a census of 34 residents and the sample included 16 residents. Based on staff interview and closed record review, the facility failed to notify the physician for 4 of 5 resident's (#30, #18, #11, and #32) with a change in health status.

Findings included:

- Review of resident #30's closed record revealed he/she was admitted to the facility on 3/11/14 with diagnoses of bi-polar (major mental illness that caused people to have episodes of severe high and low moods) type 1, polysubstance (the use of three or more groups of addictive substances over a 12 month period) abuse, and personality disorder.

The admission Minimum Data Set (MDS) dated 3/24/14 revealed the resident had disorganized thinking, was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13, had hallucinations (sensing things while awake that appear to be real, but the mind created)/delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), verbal behaviors that occurred on 4 to 6 days during the past 7 days, and had behaviors directed towards others daily.

Review of the nurse's note dated 3/26/14 at 3:15 P.M. revealed the resident was yelling foul language at staff, went into administrator's office and swept everything off the desk, refused medications, and the facility called the police.

Review of the nurse's note dated 3/26/14 at 4:00 P.M. revealed the facility called the resident's family to inform him/her the resident would be screened to go to the state hospital after

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F 157	Continued From page 2 exhibiting destructive, violent behavior. Review of the nurse's notes dated 3/26/14 lacked documentation the physician was notified of the resident's increased and destructive behaviors. On 7/22/14 at 12:36 P.M. administrative nursing staff E revealed he/she notified the doctor of any changes in a resident's condition and received orders before screening or discharging a resident. He/she revealed when a resident was screened to go to the state hospital it was a "done deal" and he/she never had to write an order for the resident to go to the state hospital. On 7/22/14 at 4:00 P.M. administrative nursing staff D revealed the physician would be notified of changes in the residents and orders were received prior to screenings. The facility provided an undated pamphlet titled Resident Rights (Form 2136R) which stated under "section 483.10(11)(i)(B) a facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there was a significant change in the resident's physical, mental, or psychosocial status..." The facility failed to notify the physician of a significant change in the resident's mental status, and transfer from the facility. - Administrative nursing staff A identified resident #18 with head lice on 3/18/14 and received treatment of Stop Lice Shampoo. Further review of the clinical record lacked evidence the facility notified the resident's	F 157		

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F 157	Continued From page 3	F 157		

physician of the presence of lice or received an order for the Stop Lice Shampoo.

Observation of the resident on 7/22/14 at 2:38 P.M. revealed resident #18 sat at the dining room table with other residents. His/her hair was short in length, he/she was well groomed and in a pleasant mood.

During an interview on 7/22/14 at 11:47 P.M. staff D stated, "we did not get an order for the treatment of lice. We know how to treat lice so we did not get an order."

The facility failed to notify the resident's physician this resident had lice.

- Administrative nursing staff A identified resident #11's roommate had head lice on 3/18/14 and received a treatment of Stop Lice Shampoo.

Further review of the clinical record lacked evidence the facility notified the resident's physician of the presence of lice on this resident's roommate and see if he/she wanted to treat this resident.

During an interview on 7/22/14 at 11:47 P.M. staff D stated, "we did not get an order for the treatment of lice. We know how to treat lice so we did not get an order."

The facility failed to notify the resident's physician of the presence of lice on this resident's roommate.

- Administrative nursing staff A identified resident #32's roommate had head lice on 3/18/14 and received treatment of Stop Lice Shampoo.

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F 157	Continued From page 4 Further review of the clinical record lacked evidence the facility notified the resident's physician of the presence of lice or received an order for the Stop Lice Shampoo. During an interview on 7/22/14 at 11:47 P.M. staff D stated, "we did not get an order for the treatment of lice. We know how to treat lice so we did not get an order." The facility failed to notify the resident's physician of the presence of lice on this resident's roommate.	F 157		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This Requirement is not met as evidenced by: The facility identified a census of 34 residents. The sample included 16 residents. Based on observation, record review, and staff interview, the facility failed to resolve the grievance of resident #31's property broken by resident #14. Findings included: - The 7-11-14 Quarterly Minimum Data Set (MDS) for resident #31, noted the resident's Brief Interview for Mental Status (BIMS) score of 15 which indicated he/she was cognitively intact., had no memory problems, and was independent with Activities of Daily Living (ADL's), required supervision with set up for meals, and one person physical assist with hygiene. The resident had no	F 166		

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F 166	Continued From page 5 reported behaviors. Interview on 7/16/14 at 2:24 P.M. resident #31 stated resident #14 took his/her jewelry box and attempted to hit him/her with it. The resident reported his/her jewelry box broke and he/she no longer had the jewelry box. On 7/21/14 at 10:38 A.M. administrative staff A revealed resident #31's jewelry box was broken in an incident when resident #14 threw it or tried to hit resident #31 with the box on 12/22/14. He/she stated that social service designee HH was going to see if the jewelry box could be fixed, but was not sure if it was. On 7/21/14 at 11:01 A.M. social service designee staff HH revealed the jewelry box was in his/her office and was not fixed. He/she stated the latch was broke and the inside wood frame needed to be fixed. He/she stated they took it to be fixed, but the latch was broken and since it was an antique it could not be matched. He/she stated they had not found anyone who could fix the jewelry box. He/she stated they could get it fixed but the hinge would not match if it was okay with the resident. He/she did not remember if they offered the resident to put a different hinge on the jewelry box. On 7/22/14 at 10:36 A.M. resident #31 revealed on 7/21/14 was the first time staff had talked to him/her about the broken jewelry box since the incident in December 2013 and said they were going to get the box fixed, he/she would like the box back because it was a gift from a spouse and was an antique. He/she stated they did not say anything to him/her about the hinge not matching, but even if it did not he/she wanted it fixed. He/she did not know staff still had the box.	F 166		

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F 166	Continued From page 6 On 7/22/14 at 3:00 P.M. administrative nursing staff D revealed when residents' property was broken, they try to fix it if they can for the resident at the facility's expense. He/she stated they were not sure if the jewelry box was repaired. He/she knew the social service designee checked a few places and the resident's child said he/she was going to also try to get it fixed. He/she stated the family was made aware of the broken jewelry box in the care plan meeting the following week. He/she stated they would expect documentation of the incident and communication with the family to be on the resident's chart. He/she stated an incident report was filled out and someone should have documented what was done. Review of resident's record lacked documentation of the incident, notification of the family, or progress of having the jewelry box repaired. The facility provided an undated pamphlet titled Residents Rights (Form 3126R) which stated under "section 483.10 (f) (1) the resident has a right to voice grievances without discrimination or reprisal... and(2) prompt efforts by the facility to resolve grievances a resident might have..." The facility failed to resolve the resident's grievance to fix his/her jewelry box in a timely manner.	F 166		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for	F 167		

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F 167	Continued From page 7	F 167		

examination and must post in a place readily accessible to residents and must post a notice of their availability.

This Requirement is not met as evidenced by:
The facility had a census of 34 residents. Based on observation, interview, and record review the facility failed to post the location of the survey results for 4 of 4 days onsite of the survey.

Findings included:

- Observation on 7-16-14 at 9:05 A.M. ,7-17-14 at 11:55 A.M., 7-21-14 at 2:30 P.M., and 7-22-14 at 1:45 P.M. revealed the notebook containing the survey results was on wall to the side of the bulletin board in the hallway by the administrator's office.

Confidential interviews on 7-21-14 and 7-22-14 with three alert and oriented residents revealed they were unaware where they could find and examine the survey results.

Interview on 7-22-14 with social service/activity staff HH said he/she took minutes at the monthly Resident Council Minutes. Review of the resident council minutes lacked documentation the location of the survey results was reviewed with the residents. Further statements made by social service/activity staff HH revealed he/she thought residents were aware the results were available because they were out in the hall.

The facility provided an undated pamphlet titled Resident Rights (Form 3126R) which stated under "section 483.10 (g) (1) a resident had the right to examine the results of the most recent

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F 167	Continued From page 8 survey of the facility conducted by Federal or State surveyors and any plan of correction...must make the results available for examination in a place readily accessible to resident and must post a notice of their availability..." The facility failed to post the location of the survey results.	F 167		
F 174 SS=D	483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The facility identified 3 residents with cellular telephones. Based upon record review and interviews the facility failed to ensure residents with cellular telephones had the right to reasonable access to his/her telephone. Findings included: - Review of the facility's cellular phone contract included: Absolutely no pictures would be taken of any residents or any part of the facility. The facility conducted random checks of cell phones and if any photos were on the phone the facility took away the resident's phone and would not return the cellular phone. Residents would not make phone calls for other residents on his/her cell phone and if the resident did, the facility took the resident's phone and would not return the phone to the resident. The facility performed random checks looking for phone numbers dialed and any questionable number(s) would be checked. If a call was made in reference to or for	F 174		

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F 174	Continued From page 9 another resident the facility took the resident's phone. Residents gave the cell phones to the nurse by 8:00 P.M. every evening and if residents did not turn the phone in by 8:00 P.M. each evening, the facility would not give the phone back the next day. Review of a resident's clinical record revealed the facility voided the resident's cell phone contract due to misuse. The contract did not reveal the date the facility voided the resident's cell phone contract or how the resident had misused his/her cell phone. During interview with a resident on 7/21/14 at 1:45 P.M. the resident stated he/she turned his/her cell phone into the facility each night at 8:00 P.M. The resident stated if he/she did not turn in his/her phone each night the facility would place an alert bracelet and he/she would not be allowed outside by himself/herself. The resident stated he/she enjoyed walking outside by himself/herself and did not want to lose that privilege. The resident stated his/her family paid for his/her cell phone. During interview with social service staff HH on 7/22/14 at 3:15 P.M., he/she stated families of the residents purchased and paid for the resident's cell phone. Social service staff HH confirmed residents had to turn the phones in each night at 8:00 P.M. to ensure the resident's phone were not stolen or used by unauthorized individuals. The facility failed to allow residents access to their telephones as they wished.	F 174		
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a	F 203		

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F 203	Continued From page 10	F 203		

resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.

Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.

The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of

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the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

This Requirement is not met as evidenced by:
The facility had a census of 34 residents, the sample included 16 residents. Based on staff interview and closed record review, the facility failed to notify the family of the date of transfer to the state hospital for one resident (#30).

Findings included:

- Review of resident #30's closed record revealed he/she was admitted to the facility on 3/11/14 with diagnoses of bi-polar (major mental illness that caused people to have episodes of severe high and low moods) type 1, polysubstance (the use of three or more groups of addictive substances over a 12 month period) abuse, and personality disorder (a type of mental disorder in which you have a rigid and unhealthy pattern of thinking, functioning and behaving).

The admission Minimum Data Set (MDS) dated 3/24/14 revealed the resident had disorganized thinking, was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13, had hallucinations (sensing things while awake that appear to be real, but the mind created)/delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), verbal behaviors that occurred on 4 to 6 days during the past 7 days, and had behaviors directed towards others daily.

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F 203	Continued From page 12 Review of the nurse's note dated 3/26/14 at 3:15 P.M. revealed the resident was yelling foul language at the staff, went into administrator's office and swept everything off the desk, refused medications, and the facility called the police. Review of the nurse's note dated 3/26/14 at 4:00 P.M. revealed the facility called the resident's family to inform him/her the resident would be screened to go to the state hospital after exhibiting destructive, violent behavior. Review of the nurse's notes dated 3/26/14 lacked documentation the facility notified the family the date of the resident's transfer or provided written notice to the family. On 7/22/14 at 12:36 P.M. administrative nursing staff E revealed he/she notified the doctor of any changes in a residents condition and received before screening or discharging a resident. He/she revealed when a resident was screened to go to the state hospital it was a "done deal" and he/she never had to write an order for the resident to go to the state hospital. On 7/22/14 at 4:00 P.M. administrative nursing staff D revealed the physician was notified of changes and orders were received prior to screenings. The facility provided an undated pamphlet titled Resident Rights (Form 2136R) which stated under "section 483.12(a)(4)(i) before a facility transfers or discharges a resident, the facility must (i) notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing in a language and manner they	F 203		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 203	Continued From page 13 understand, (ii) record the reasons in the resident's clinical record." The clinical record lacked evidence the date the resident was transferred from the facility.	F 203		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 16 residents. Based upon observation, record review and interviews the facility failed to ensure 1 (#12) of 5 residents sampled for abuse was free from abuse. Findings included: - Resident #12 Physician's Order Sheet dated and signed 6/25/14 included the resident had a diagnosis of urinary incontinence (loss of control of the bladder). The resident's quarterly Minimum Data Set (MDS) 3.0 dated 6/28/14 identified the resident scored 13 (cognition intact) on the Brief Interview for Mental Status, had delusions (- untrue persistent belief or perception held by a person although evidence shows it was untrue), other behavioral symptoms directed toward others, was independent with bed mobility, transfers, walking in the room/corridor, locomotion on the unit and	F 223		

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	17E256	A. BUILDING _____ B. WING _____	07/24/2014

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required limited staff assistance with locomotion off the unit, and personal hygiene and staff supervision with dressing, eating and toilet use. The MDS recorded the resident had an impairment on one side of his/her upper extremity and impairments on both sides of his/her lower extremities, was frequently incontinent of urine and was on a toileting program.

The resident's Activities of Daily Living (ADL) Functional Status/Rehabilitation Potential Care Area Assessment (CAA) dated 3/28/14 documented the resident was at risk for an ADL deficit due to diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and dementia (progressive mental disorder characterized by failing memory, confusion) and the resident's legs were unbalanced.

The resident's Urinary Incontinence and Indwelling Catheter CAA dated 3/28/14 included the resident was incontinent of urine due to diagnoses of schizophrenia and dementia.

The resident's Bladder Incontinence Evaluation dated 7/2/14 and timed 6:00 A.M. included the resident had an increase in the number of incontinent episodes, did not have a urinary tract infection and staff questioned if the resident had a change in behavior. The evaluation included staff toileted/prompted the resident every 2 hours.

The evaluation lacked evidence as to what interventions staff implemented to minimize the resident's increase in incontinent episodes.

The resident's clinical record lacked evidence the facility performed a 3 day voiding assessment

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after the facility observed the resident had an increase in incontinence.

The resident's temporary care plan dated 6/9/14 included staff toileted the resident every 2 hours. If the resident was incontinent of urine in the dining room the lobby or halls the resident lost his/her soda privileges the next day.

The resident's care plan dated 7/3/14 included the resident had an alteration in elimination related to mixed urinary incontinence. Staff awakened the resident at regular intervals during the night to use the bathroom, the resident saw the urologist as scheduled and staff administered the resident's medications as the physician ordered. The resident wore an incontinent brief at night and the resident's incontinence bed pad was wet at times. Staff cued the resident to toilet every 2 hours during the day. The resident lost his/her soda privileges if he/she was incontinent in the lobby, the dining room, nurse's station, or hallway since it was a behavior unless the resident had a urinary tract infection. The resident's guardian would not take the resident out of the facility until he/she had no incontinence episodes for 2 weeks. The care plan included the resident refused to wear incontinence products during the day.

The resident's care plan did not include the facility educated the resident or the resident's guardian on the advantages of wearing an incontinence pad during the day.

The resident's clinical record lacked evidence the facility had thoroughly assessed the cause of the resident's urinary incontinence prior to denying the resident his/her soda privileges. The resident's clinical record lacked evidence the

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facility implemented other interventions prior to denying the resident his/her soda. The resident's clinical record also lacked evidence the facility developed a behavior modification program (a treatment used in the mental health-care field to deal with certain types of antisocial behavior).

The resident's 24 hour voiding diary dated 1/8/14 included the resident was incontinent of urine at 11:50 A.M. An entry titled conclusion documented the resident remained dry if toileted every 2 hours.

The resident's 4/3/14, 24 hour voiding diary included the resident was incontinent of urine at 2:00 P.M. An entry titled conclusion documented the resident continued to have incontinent issues.

A nurse's note (NN) dated 6/22/13 and timed 11:30 A.M. included the resident had a urethral dilatation (procedure that stretched the urethra - the tube that allowed urine to pass out of the body) and staff received a physician's order to administer 2 doses of Keflex (an antibiotic) 500 milligrams.

A NN dated 1/7/14 and timed 8:15 A.M. included the resident urinated on the dining room floor and staff assisted the resident to the bathroom.

A NN dated 1/8/13 and timed 1:10 P.M. included the resident was incontinent of urine in various places and the resident had his/her urethra dilated on 12/24/13.

A NN dated 6/26/14 (time unknown) included the resident urinated in the dining room after snacks and the resident would not receive a soda the rest of the day or evening.

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On 7/22/14 at 9:30 A.M., 9:45 A.M., 9:50 A.M. and 10:00 A.M. the resident sat in a chair in the lobby area of the facility. At 10:10 A.M. 10:15 A.M. and 10:20 A.M. the resident received fluids during snack time in the dining room. At 10:30 A.M. the resident ambulated from the dining room to the lobby area of the facility and sat in a chair.

On 7/22/14 at 10:40 A.M. the resident ambulated independently to the bathroom. Observation revealed the resident did not wear an incontinent brief and was not incontinent of urine. During interview with the resident at that time the resident stated staff did not prompt him/her to go to the bathroom, he/she toileted himself/herself.

Observation revealed no staff prompted/cued the resident to toilet after snack time.

On 7/22/14 at 1:20 P.M. the resident ambulated down the hallway and administrative nursing staff E stated the resident was going to the bathroom. Administrative nursing staff E sat at the nurse's station stated no one had prompted/cued the resident to go the bathroom. Administrative nursing staff E stated the resident knew when he/she needed to use the bathroom.

On 07/16/14 at 2:41 P.M. a resident expressed concern he/she would lose his/her soda privileges if he/she did not comply with the facility rules.

On 7/21/14 at 1:45 P.M. a different resident stated he/she would lose his/her privileges if he/she did not comply with the facility rules.

On 7/22/14 at 11:19 A.M. direct care staff O stated staff prompted/toileted the resident every 2 hours. Direct care staff O stated depending upon his/her workload he/she did not always

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prompt/toilet the resident every 2 hours. Direct care staff O stated he/she bathed the resident around 9 A.M., the resident was not incontinent of urine at that time and he/she did not prompt/toilet the resident since that time.

On 7/22/14 at 1:19 P.M. licensed nurse E stated the resident was incontinent of urine at times, staff reminded the resident to toilet after each meal, after snack times and anytime staff thought the resident sat for an extended period of time. Licensed nurse E stated since staff reminded the resident at the times mentioned above, the resident's incontinence was intentional. Licensed nurse E stated the resident was capable of going to the bathroom by himself/herself and without staff reminders to toilet. Licensed nurse E stated if the resident was incontinent in the dining room, in the lobby or in the hallway the resident lost his/her soda privilege for the day. Licensed nurse E stated the department heads and himself/herself discussed resident's behavior and decided which privileges the resident lost based on the resident's behavior. Licensed nurse E stated the resident and/his/her guardian were not a part of the decision making process. Licensed nurse E stated the facility performed a 24 hour voiding diary and not a 3 day voiding diary. Licensed nurse E stated the resident wore underwear without a pad during the day, and an incontinent brief at night. Licensed nurse E stated the resident did not like to wear a pad during the day.

On 7/22/14 at 3:55 P.M. administrative nursing staff D stated the resident was incontinent of urine at times. Administrative nursing staff D stated staff prompted the resident to toilet every 2 hours. Administrative nursing staff D stated when staff prompted the resident to toilet every 2 hours,

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F 223	Continued From page 19 the resident was less incontinent. Administrative nursing staff D stated when the resident was incontinent in the dining room, the lobby, or in the hallway the incontinence was a behavior and the resident lost his/her soda privileges. Administrative nursing staff D stated the department heads decided which privileges residents lost based on the resident's behavior. Administrative nursing staff D confirmed the resident had a diagnosis of urinary incontinence and at times had his/her urethra dilated. Administrative nursing staff D stated the facility performed a 24 hour voiding diary versus a 3 day voiding diary and the resident wore underwear without a pad during the day and an incontinence brief at night. The facility failed to thoroughly assess the cause of the resident's urinary incontinence and failed to include the resident and his/her guardian in the decision making process prior to implementing restrictions for this resident with a medical diagnosis of urinary incontinence.	F 223		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations	F 225		

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F 225	Continued From page 20 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 16 residents. Based upon record review and interviews the facility failed to investigate allegations of abuse for 2 (#22, #31) residents of the sample. Findings included: - Resident #22's quarterly Minimum Data Set (MDS) 3.0 dated 4/25/14 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, had delusions (untrue persistent belief or perception held by a person although evidence showed it was untrue), was independent with bed mobility, transfers, walking in the room/corridor, locomotion on the unit,	F 225		

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dressing, and eating, required staff supervision with locomotion off the unit and personal hygiene and he/she received an antipsychotic medication 7 of the 7 days during the assessment period.

The resident's Activity of Daily Living (ADL) Functional Status/Rehabilitation Potential Care Area Assessment (CAA) dated 10/23/13 included the resident was at risk for a decline in his ADLs due to a diagnosis of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language, communication and fragmentation of thoughts) and the use of psychotropic medications.

The resident's Psychotropic Medication CAA dated 10/23/13 included the resident received psychotropic medications and had a diagnosis of schizophrenia.

The resident's care plan dated 5/1/14 included the resident received psychotropic medications, was very delusional but was quieter.

A nurse's note dated 4/2/14 and timed 8:00 P.M. included the resident sat in the lobby and chatted with peers and 2 police officers entered the facility. The officers reported to the nurse the resident telephoned and said staff was beating him/her up. At 8:15 P.M. the resident spoke with the officers in his/her room. At 8:25 P.M. the officers left the facility and the nurse informed the resident he/she was withholding his/her night cigarette for his/her behavior. The resident became angry, threw things around and the nurse contacted administrative nursing staff E. The resident spoke on the phone with the staff and staff allowed the resident his/her cigarette tonight with further cooperation with staff until staff met the next day to discuss the matter.

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F 225	Continued From page 22 0n 7/16/2014 at 1:36 P.M. the resident stated a licensed nurse grabbed him/her by the arm which caused a bruise on his/her arm. The resident stated staff informed administrative nursing staff D and administrative nursing staff D spoke to him/her about the incident. The resident stated it was his/her understanding administrative nursing staff D reported the incident to administrative staff A. On 7/21/14 at 10:15 A.M. administrative nursing staff A stated he/she was not aware of the incident; therefore the facility did not investigate the allegation of abuse or contact the state agency. On 7/21/14 at 2:20 P.M. administrative nursing staff D stated he/she was unaware of the incident and staff did not inform him/her of the incident per telephone as documented in the nurse's notes. On 7/22/14 at 11:16 A.M. direct care staff O stated he/she had no knowledge of the incident and did not see staff abuse the resident. Direct care staff O stated a resident overheard the resident informing the surveyor a staff (gave the staff name) abused the resident. Direct care staff O stated the resident who overheard the conversation reported what the resident stated to staff. The facility's Investigation of Abuse, Neglect or Exploitation (ANE) Policy and Procedure reviewed and updated 11/2009 included in the event an employee was suspected or accused of ANE, administration determined if sufficient hard evidence or circumstantial evidence existed to warrant an investigation. If an investigation was deemed necessary the facility followed the	F 225		

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following steps: the charge nurse notified the administrator or his/her agent immediately after the situation was reported or discovered, the facility placed the employee on administrative leave until the situation was resolved and the facility notified the appropriate state agency...

The facility failed to investigate the allegation of abuse and failed to report the allegation of abuse to the state agency.

- The signed Physician's Order Sheet dated 6-25-14 for resident #31 listed diagnosis of schizoaffective (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) disorder-bipolar (major mental illness that caused people to have episodes of severe high and low moods) type.

The 7-11-14 Quarterly Minimum Data Set (MDS) noted the resident's Brief Interview for Mental Status (BIMS) score of 15 which indicated he/she was cognitively intact, had no memory problems, and had no reported behaviors.

On 7/16/14 at 2:24 P.M. resident #31 stated resident #14 took his/her jewelry box and attempted to hit him/her with it. The resident stated a staff member had to stop the resident from hitting him/her. The resident stated he/she was not actually hit, but it scared him/her. The resident reported his/her jewelry box broke and he/she no longer had the box.

On 7/21/14 at 10:38 A.M. administrative staff A revealed he/she was aware of an incident between resident #31 and resident #14 where a jewelry box was broken. Administrative staff A stated the residents where roommates at the time

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and did not get along. He/she stated he/she and Social Service Designee HH spoke with resident #31 the following day. He/she stated it was his/her understanding the resident swung his/her arm across resident #31's dresser and knocked the jewelry box to the floor. Administrative staff A stated they did not believe the resident was in danger. He/she understood social service designee HH was going to see if the jewelry box could be repaired, but was unsure of the status.

On 7/21/14 at 11:01 A.M. social service designee HH revealed he/she still had the jewelry box and it was not fixed. He/she acknowledged the staff who intervened in this situation should had completed an investigation.

On 7/22/14 at 6:49 A.M. licensed nursing staff I revealed he/she could not remember the incident, but thought when he/she entered the room the residents had a spat and were getting ready for bed. He/she revealed staff kept an eye on the residents every 5 minutes, and there were no further problems. He/she stated resident #31 said resident #14 was throwing his/her things, but he/she did not witness anything being thrown. In reviewing resident #31's chart with licensed nursing staff I, the nurse acknowledged he/she failed to document the incident. Further review of resident #14's chart with licensed nursing staff I revealed he/she had documented on 12/22/13 at 7:10 P.M. the staff heard yelling down the hall and found resident #14 standing over resident #31's side of the room, threw items at him/her, including a wooden jewelry box that hit the floor and two glass vases which landed on the bed. He/she documented there were no injuries to resident #31, and resident #14 was directed to the lobby where staff could watch him/her. He/she documented verbal reassurance was

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provided to resident #31. Licensed nursing staff I then stated what was documented in his/her nursing note would be accurate, and he/she would not have documented it if it was not, and acknowledged he/she failed to document this incident in resident #31's chart.

On 7/22/14 at 10:36 A.M. resident #31 revealed on the day of the altercation resident #14 tried to hit him/her with the jewelry box and an aide stopped him/her. Resident #31 stated he/she slept in a different room that night because he/she was terrified. He/she stated resident #14 was moved they think the next day to a different room.

On 7/22/14 at 12:37 P.M. administrative nursing staff E revealed he/she documented altercations between residents in the nursing notes. A nursing note dated 12/22/13 at 7:30 A.M. in resident #14's chart written by administrative nursing staff E revealed resident #14 was upset when staff came in this morning and he/she had the resident come sit at the desk with him/her. Further notation revealed resident #14 jumped up suddenly and said he/she was going to take care of that peer once and for all. Administrative nursing staff E stated he/she let the administrator, director of nursing, and social service designee know about the incident, and they met with the residents. He/she stated there were no further altercations between the residents.

On 7/22/14 at 3:00 P.M. administrative nursing staff D stated he/she would expect staff to immediately go to a room when there were altercations between residents. He/she stated the residents would be split up and brought to the lobby where they were watched. He/she stated when incidents occur the care plan team

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F 225	Continued From page 26 interviews the residents together. These two residents were interviewed together and resident #14 denied picking up or throwing any of resident #31's belongings. He/she stated resident #31 stated resident #14 threw a stuffed animal and pillow at him/her and pushed the jewelry box to the floor. Administrative nursing staff D stated resident #31's family knew about the incident, it was reported to him/her during the care plan meeting the following week. He/she acknowledged generally an investigation was completed on both residents and someone should have documented interventions in the medical record. On 7/22/14 at 3:30 P.M. administrative staff A confirmed there was no investigation completed because it was not resident to resident abuse. He/she stated they would report physical to physical abuse and there was no contact between the two residents, and it was not one-sided. Administrative staff A stated both residents were competent in saying if they were hurt and it was just over objects. Review of resident #31's medical record lacked nursing or social service documentation regarding the incident with resident #14. The facility's Investigation of Abuse, Neglect or Exploitation Policy and Procedure reviewed and updated 11/2009 included for resident to resident abuse, the facility notified the appropriate state agency within 24 hours after the incident was reported and submitted a report to the appropriate state agency within five working days. The facility failed to investigate and report this incident to the state agency.	F 225		
F 226	483.13(c) DEVELOP/IMPLMENT	F 226		

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F 226 SS=D	Continued From page 27 ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Requirement is not met as evidenced by: The facility had a census of 34 residents. Based upon record review and interviews the facility failed to include all the required components in the facility's Abuse, Neglect, and Exploitation Policy and Procedure, failed to perform reference checks for 2 of 2 employee files reviewed and failed to follow up on the criminal background check for 1 of 2 employee files reviewed. Findings included: - Review of the facility Investigation of Abuse, Neglect or Exploitation (ANE) policy and procedure reviewed/updated 11/2009 revealed the policy and procedure did not include prevention and identification. The policy included if an incident occurred after hours or on the weekend and the abuse hotline was closed, the facility notified law enforcement if the facility determined actual abuse occurred. The policy did not include the timeframe for reporting reasonable suspicion of a crime. The facility failed to ensure all required components were included in the facility's ANE policy and procedure. - Review of direct care staff Q personnel file revealed the employee's date of hire was 5/6/14. Further review revealed the facility requested a	F 226		

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F 226	Continued From page 28 criminal background check (CBC) request on 5/13/14. Review of the resident's employee file lacked evidence the facility followed up on the CBC to ensure the employee was not prohibited from working in a nursing facility. Review of the resident's employee file lacked evidence the facility checked with the employee's previous employers for references. On 7/17/14 administrative staff A confirmed the resident's employee file lacked evidence the facility performed reference checks. Administrative staff A stated the facility did not follow up on the CBC's and the state agency sent the facility a letter if the employee was prohibited from working in a nursing facility. The facility's Investigation of Abuse, Neglect or Exploitation Policy and Procedure reviewed and updated 11/2009 included the facility to contact previous employees for references and to perform a background check once the facility offered the employee a position. The facility failed to contact the employee's previous employers for references and failed to follow up on the CBC.	F 226		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This Requirement is not met as evidenced by:	F 242		

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F 242	Continued From page 29 The facility identified a census of 34 residents. The sample included 16 residents. Based on observation, interview, and record review the facility failed to provide choices for 6 residents of the sample. Findings included: - Confidential interview on 7/16/14 at 2:57 P.M. revealed the resident had to stay up for medication pass at 8:30 P.M. and could go to bed afterwards. Review of the care plan lacked interventions for the time preferred by this resident to go to bed at night. The record lacked evidence the facility assessed the resident's preferences for the times he/she preferred to go to bed at night. An observation on 7/22/14 at 10:57 A.M. the resident sat in the living room watching television and talked with another resident. - Confidential interview on 7/16/14 at 2:57 P.M. revealed a different resident had to stay up for medication pass at 8:30 P.M. and could only go to bed afterwards. - During a confidential interview with another resident on 7/17/14 at 8:17 A.M. the resident stated he/she did not chose when he/she got up in the morning, he/she stated everyone got up at the same time for breakfast and if you did not get up in time you would not receive breakfast. He/she stated the residents could not go to bed when they would like because they had to stay up for their medications and snack.	F 242		

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F 242	Continued From page 30 - During a confidential interview with a different resident on 7/16/14 at 3:28 P.M. revealed he/she had to get up for breakfast so he/she would not be late and the food would not get cold. He/she stated the residents got up around 7 A.M. and if he/she was not out of his/her room by 8:00 A.M. the food was thrown away. He/she stated if a resident was late for his/her 8:00 P.M. medications, staff would call their names over the voice system and the residents had to go up to the nurses' station to get their medications. If a resident did not go up to the nurses station then on very rare occasions the staff may bring the residents their medications. The resident stated if he/she went to bed early then he/she would have to get up for his/her medications. - During a confidential interview with another resident on 7/16/14 at 8:17 A.M. the resident revealed the residents did not choose when to get up in the morning. He/she stated everyone was supposed to get up at the same time for breakfast or else they would not get any breakfast. He/she stated the residents did not choose when to go to bed at night, they went to bed after night time medication pass and snack. Interview on 7/22/14 at 9:40 A.M. licensed nursing staff H stated the residents received their night medications at 8:30 P.M. if they were non-smokers. If they were smokers they were allowed to smoke and then received their medications at 8:45 P.M. If the resident was sleeping in his/her room at 8:30 P.M. staff would get the resident up and let them know to come to the nurses' station to receive their medications. Staff H stated he/she did not take medications to the resident if they were sleeping at 8:30 P.M. Staff H stated the residents sit in the common area and he/she called them one by one to take	F 242		

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F 242	Continued From page 31 their night time pills, then they can go to bed. The facility provided the Residents Rights pamphlet initialed and dated by administrative staff A documented the facility must care for its residents in a manner and an environment that promoted maintenance or enhancement of each resident's quality of life. The resident had the right to make choices about aspects of his or her life in the facility that were significant to the resident. The facility failed to assess and provide the resident's choices and preferences for when to wake up and go to bed. - During Stage 1 of the survey on 7/16/14 and 7/17/14, 16 of 29 residents expressed concerns regarding choices. Concerns included residents getting up and going to bed times, bath/showers choices, not having a water pitcher in their room, and snacks. A resident stated he/she had to get out of bed between 6:30 to 7:00 A.M. to get dressed and be ready for breakfast at 7:30 A.M. The resident stated if he/she was not ready for breakfast by 7:30 A.M. he/she would lose his/her soda privileges. Residents stated they could not go to bed until after the 8:30 P.M. medication pass. The residents stated if they went to bed prior to 8:30 P.M., they had to get up at 8:30 P.M. and go to the nurses' station to receive his/her medications because staff would not bring residents their 8:30 P.M. medications. A resident stated the nurse called his/her name over the intercom until he/she came to the nurses' station to take his/her 8:30 P.M. medications.	F 242		

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Residents stated they did not receive sufficient fluids between meals and they would like a water pitcher in their rooms. Residents stated they could purchase soda at 10:00 A.M. and 2:30 P.M., received fluids at meals and at 8:00 P.M. If they wanted fluids after that time they had to use the water fountain located by the nursing station. One resident stated if he/she was really thirsty he/she drank water from the sink in the bathroom.

Observation during Stage 1 of the survey on 7/16/14 and 7/17/14 and on 7/21/14 at 7:30 A.M. and 3:00 P.M. and on 7/22/14 at 7:30 A.M. and 3:00 P.M. revealed residents did not have water pitchers or cups in their rooms.

On 7/14/14 at 10:00 A.M. observation revealed morning delight included residents gathered in the dining room. Administrative staff HH gave residents if requested 75 cents which the facility deducted from the resident's personal fund account and resident's purchased a soda from the vending machine and a cereal bar for a quarter from the facility. The facility offered water to residents. The residents ate/drank the snack and fluids and then exited the dining room after the snack time.

On 7/14/14 at 2:30 P.M. afternoon delight consisted of the same as described above at 10:00 A.M. Observation revealed social service staff/activity staff HH gave residents $1.00 in quarters if the residents requested, to purchase soda/snack from the vending machine.

On 7/22/14 at 2:00 P.M. observation revealed a music activity in the dining room.

On 7/22/14 at 2:40 P.M. a resident asked for a

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snack from a display of snacks. Social service/activity staff HH informed the resident, he/she did not attend the activity; therefore he/she could not receive the free snack and had to purchase his/her snack. Observation revealed social service/activity staff HH gave the resident 4 quarters.

On 7/17/14 at 3:00 P.M. administrative staff A stated an employee of the facility owned the vending machines.

On 7/22/14 at 3:55 P.M. administrative nursing staff E stated the evening nurse encouraged residents to stay up until the 8:30 P.M. medication pass. Administrative nursing staff E stated some nurses took the residents the 8:30 P.M. medications and other nurses did not. Administrative nursing staff E stated residents did not have water pitchers in their room because some residents drank water excessively, residents would take other resident's water pitchers and residents would knock over water pitchers which made it unsafe. Administrative nursing staff E stated he/she had worked at the facility for 4 years and staff had not placed water pitchers in resident's room during that time. Administrative nursing staff E stated the facility served breakfast at 7:30 A.M. and would not serve a hot breakfast after 9:00 A.M.

On 7/22/14 at 12:58 P.M. dietary staff DD stated the snack time scheduled at 10:00 A.M. and 2:30 P.M. dietary provided 360 cubic centimeters (cc's) of water to the residents and at the 8:00 P.M. snack the facility provided 120 cc's of milk or lemonade to the residents. Dietary staff DD stated after the 8:00 P.M. snack, residents received water with the 8:30 P.M. medication pass and if residents wanted fluids after that time

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the residents used the water fountain.

On 7/22/14 at 2:11 P.M. dietary staff DD stated the facility served breakfast at 7:30 A.M. and the residents had until 8:00 A.M. to get to the dining room and after that time staff removed the food from the table. Dietary staff DD stated depending upon the time (after 8:00 A.M.) the facility may give the resident's fluid, fruit or bowl of cereal. The surveyor asked dietary staff DD to explain the above statement and dietary staff DD stated if it was close to snack time the facility would not provide the food/fluid the resident would receive the snack (purchased by the resident).

On 7/22/14 at 3:15 P.M. social service staff HH stated one of the residents had expressed concerns regarding receiving his/her baths on the evening shift. Social service staff HH stated the facility chose not to have the resident receive his/her shower on the evening shift because more staff was available on the day shift in the event anything happened. Social service staff HH stated residents received $1.75 per day for snacks/sodas (75 cents at 10:00 A.M. and $1.00 at 2:30 P.M.) Social service staff HH stated at 10:00 A.M. residents could purchase a cereal bar (purchased by the facility) for 25 cents and a soda for 50 cents and at 2:30 P.M. residents could purchase a pop and a snack (50 cents each) from the vending machine. Social service staff HH stated the vending machines were only available at 10:00 A.M. and 2:30 P.M. Social service staff HH stated if residents received the $1.75 (which the facility deducted from the resident's personal fund account) as noted above the residents had to spend the money as described above and could not purchase soda/snacks at a later time. Social service staff HH stated the cost of the pop was 55 cents and

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the facility paid the nickel if the resident purchased the soda from the machine. Social service staff HH stated the facility encouraged residents to attend activities and if free snacks were provided after an activity, residents received the free snack if they attended the activity. Social service staff HH stated the volunteer that conducted the music activity on 7/22/14 provided the snack.

On 7/22/14 at 4:19 P.M. administrative staff A stated the facility served the breakfast meal at 7:30 A.M. and staff encouraged residents to come to breakfast. Administrative staff A stated if residents woke up between 9:00 to 9:30 A.M. the resident would not receive a breakfast meal but would get the snack. Administrative staff A stated the facility offered water at the 10:00 A.M. snack and residents purchased the cereal bar for 25 cents and the soda for 50 cents and the facility contributed 5 cents for the soda. Administrative staff A stated the facility did not want residents to go without food and if the resident did not have funds to purchase the snack the facility would find crackers/cookies for the residents. Administrative staff A stated the facility encouraged residents to attend activities and the volunteer that provided the Tuesday evening and Thursday activity provided the food/fluid and whoever sponsored bingo supplied the snack (facility or volunteer) on Tuesday it was a snack and on Thursday it was a soda. Administrative staff A stated residents only received the free snack if they attended the activity. Administrative staff A stated residents received 0.75 cents at 10:00 A.M. and $1.00 at 2:30 P.M. and residents had to spend the money for snacks/soda as noted above during those times. Administrative staff A stated the facility did not provide water pitchers and cups in resident's rooms because

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F 242	Continued From page 36 certain residents had a tendency to over indulge and would get other resident's water pitchers from their room. Administrative staff A stated the facility had a water fountain, all residents were ambulatory and could say he/she was thirsty and wanted a drink. On 7/22/14 at 5:00 P.M. direct care staff R stated the resident had asked staff on the evening shift to give him/her a shower and staff told the resident he/she had to wait for day shift to shower him/her. Direct care staff R stated due to staff levels, only residents who did not require staff assistance received a shower during the evening. Direct care staff R stated this resident required staff assistance with his/her shower therefore he/she could not receive his/her shower on the evening shift. The facility failed to honor resident's choices regarding get up time, going to bed time, water pitchers and showers.	F 242		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 16 residents. Based on interview and record review the facility failed to follow up on resident grievances. Findings included:	F 244		

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F 244	Continued From page 37 - Interview on 7/21/14 at 12:35 P.M. with resident #15 revealed at resident council meetings residents were asked if they had any grievances. He/she then stated if there was a grievance he/she or the social service designee HH tried to get answers about the concerns. He/she stated if they did not hear back about the concern he/she went and asked. He/she stated they did not usually discuss it again at the next meeting. He/she further revealed if the concern was not addressed, he/she then talked to the administrator. An interview on 7/22/14 at 3:45 P.M. with social service designee HH revealed he/she took minutes at the resident council meetings. He/she stated most of the grievances were about hand washing and not flushing the toilet. He/she said they were taken care of immediately by reminding residents to be respectful of others. He/she stated they really did not have many grievances. He/she stated they did not document these items in the minutes and did not follow up on these in future meetings. He/she acknowledges they should document the follow up in the resident council minutes and from now on would be. Review of resident council minutes dated monthly from June 2013 through July 2014 lacked documentation of follow up to resident grievances. The facility provided an undated pamphlet titled Residents Rights (Form 3126R) which stated under "section 483.10 (f) (1) voice grievances without discrimination or reprisal...(2) prompt efforts by the facility to resolve grievances a resident might have..."	F 244		

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F 244	Continued From page 38 The facility failed to provide documentation resident grievances were resolved in a timely manner.	F 244		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 16 residents. Based upon observation, record review and interviews the facility failed to provide for the residents an ongoing program of activities including weekend and evenings. Findings included: - Review of the facility's April 2014 activity calendar included no activities scheduled after 3:30 P.M. The calendar included eat in-eat out activities scheduled on 4/1/14, 4/8/14, 4/15/14 and 4/29/14 with no time listed. The calendar included Saturday's activities included Hands Up (exercise group) scheduled at 9:30 AM, Morning Delight scheduled at 10:30 A.M., a movie at 1:30 P.M. and Afternoon Delight at 2:30 P.M. Sunday's activities included Good Morning on CBS at 8:30 A.M., Hands Up at 9:30 A.M., Morning Delight at 10:30 A.M., time with Randi at 1:30 P.M. and Afternoon Delight at 2:30 P.M. The facility's May 2014 activity calendar revealed no activities scheduled after 4:00 P.M. Saturday activities included Hands Up scheduled at 9:30	F 248		

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AM, Morning delight scheduled at 10:30 A.M., a movie at 1:30 P.M. and Afternoon Delight at 2:30 P.M. Sunday's activities included Good Morning on CBS at 8:30 A.M., Hands Up at 9:30 A.M., Morning Delight at 10:30 A.M., time with Randi at 1:30 P.M. and Afternoon Delight at 2:30 P.M.

The facility's June 2014 activity calendar included no activities scheduled after 3:00 P.M. Saturday activities included Hands Up scheduled at 9:30 AM, Morning Delight scheduled at 10:30 A.M., a movie at 1:30 P.M. and Afternoon Delight at 2:30 P.M. Sunday's activities included Good Morning on CBS at 8:30 A.M., Hands Up at 9:30 A.M., Morning Delight at 10:30 A.M., time with Randi at 1:30 P.M. and Afternoon Delight at 2:30 P.M. The activity calendar included a handwritten entry that included a church service on 6/1/14 and 6/8/14 (no time listed) and church bingo on 6/22/14 (no time included).

The facility's July 2014 activity calendar included no activity scheduled after 2:30 P.M. except on Monday 7/14/14 a concert at a local park scheduled for 7:00 P.M. and on Sunday 7/13/14 a 6:30 P.M. church service. Saturday's activities included Hands Up scheduled at 9:30 AM, Morning Delight scheduled at 10:30 A.M., a movie at 1:30 P.M. and Afternoon Delight at 2:30 P.M. Sunday's activities included Good Morning on CBS at 8:30 A.M., Hands Up at 9:30 A.M., Morning Delight at 10:30 A.M., time with Randi at 1:30 P.M. and Afternoon Delight at 2:30 P.M. (except on 7/27/14). On Sunday 7/6/14 and on Sunday 7/27/14 a church services was included with no time. On 7/27/14 the 2:30 P.M. activity included church bingo.

On 7/14/14 at 10:00 A.M. observation revealed Morning Delight included residents gathered in

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F 248	Continued From page 40 the dining room. Activity staff HH gave residents, if requested, 75 cents which the facility deducted from the resident's personal fund account and residents purchased pop from the vending machine and a cereal bar for a quarter from the facility. The facility offered water to residents. The residents ate/drunk the snack and fluids and then exited the dining room after the snack time. On 7/14/14 at 2:30 P.M. Afternoon Delight consisted of the same as described above at 10:00 A.M. During Stage 1 of the survey on 7/16/13 and 7/17/14, 12 of 29 residents stated the facility did not have sufficient activities during the evenings and on weekends. Residents stated the facility's van accommodated 6 residents; therefore not everyone who wanted, attended the concert in the park. On 7/22/14 at 3:15 P.M. activity staff/social service staff HH stated the Morning and Afternoon Delight scheduled on the activity calendar on the weekend was the same as described above. Activity staff HH stated activities were usually not scheduled after 3:00 P.M. Activity staff HH stated every other Sunday a religious service was scheduled. The facility failed to ensure residents had an ongoing activity program that included evenings and weekends.	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253	Continued From page 41 This Requirement is not met as evidenced by: The facility reported a census of 34 residents. Based on observation, record review, and interview, the facility failed to provide maintenance services to maintain an orderly and comfortable interior for residents on 2 of 2 halls and 3 of 4 days onsite of the survey. Findings included: - Observation on 7/22/14 at 7:45 A.M. during the environmental tour with housekeeping/maintenance staff X, revealed the following areas: A room on the west hall revealed a rip in the seat cushion of a resident's chair. The wall below the resident's window had chipped paint. At that time maintenance staff X reported the rip in the resident's chair was not there before and he/she fixed paint issues within the month of being notified. He/she stated the walls were painted on the east side of the building and he/she planned to paint the west side of building soon. A room on the west hall revealed chipped paint on the walls and chipped areas to the tile on the floor. A room on the west hall revealed broken tile on the floor and chipped paint on one of the four beds in the room. Plaster to one wall without paint over it to match the wall. At that time maintenance staff X reported the tile was fixed by administrator staff A's spouse within the month of being notified. He/she stated he/she agreed the bed with chipped paint looked as if it needed to be repainted.	F 253		

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F 253	Continued From page 42 A room on the east hall revealed unfilled holes in the residents' walls, there were large marks on the walls where furniture had hit it and the baseboard behind a residents' bed was discolored. At that time maintenance staff X reported he/she painted the walls and the residents continued to hit their chairs against the walls. A room on the east hall revealed several marks and holes in the walls, wall paint was chipped, and there was no cover for a light bulb on the resident's ceiling. At that time maintenance staff X reported the resident wanted something off of his/her wall and removed it leaving the holes in the wall. He/she stated the light fixture was removed by another resident and it was broken not too long ago. He/she stated it would be fixed. The dining room floor revealed broken tile and black marks on the tile floor. At that time maintenance staff X reported the tile got scuffed by the residents pushing their chairs backwards, he/she stated he/she cleaned the build up off the floors once a month due to the wear and tear from the chairs. During an interview on 7/22/14 at 7:45 A.M. with housekeeping/maintenance staff X reported there were no logs for a routine maintenance program. He/she stated he/she documented items on his/her list and completed them when he/she could. He/she stated a list was written but the list was not kept. An interview on 7/22/14 at 4:13 P.M. with Administrative staff A reported the facility ran a list for environmental tasks and once the tasks were completed they threw away the lists. He/she stated everything got fixed as quickly as possible.	F 253		

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F 253	Continued From page 43 The facility provided a policy titled Resident Room Cleaning Policy, not dated, which documented each resident would live in a clean, pleasant environment. The facility failed to provide maintenance services to maintain a sanitary and homelike environment.	F 253		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 16 residents. Based upon observation, record review and interviews the facility failed to develop an individualized toileting program for 1 of 1 (#12) residents sampled for urinary incontinence. Findings included: - Resident #12 Physician Order Sheet dated and signed 6/25/14 included the resident had a diagnosis of urinary incontinence (loss of control of the bladder). The resident's quarterly Minimum Data Set (MDS) 3.0 dated 6/28/14 identified the resident	F 315		

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scored 13 (cognition intact) on the Brief Interview for Mental Status, had delusions (- untrue persistent belief or perception held by a person although evidence shows it was untrue), other behavioral symptoms directed toward others, was independent with bed mobility, transfers, walking in the room/corridor, locomotion on the unit and required limited staff assistance with locomotion off the unit, and personal hygiene, and staff supervision with dressing, eating and toilet use. The MDS recorded the resident had an impairment on one side of his/her upper extremity and impairments on both sides of his/her lower extremities, was frequently incontinent of urine, and was on a toileting program.

The resident's Activities of Daily Living (ADL) Functional Status/Rehabilitation Potential Care Area Assessment (CAA) dated 3/28/14 documented the resident was at risk for an ADL deficit due to diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and dementia (progressive mental disorder characterized by failing memory, confusion) and the resident's legs were unbalanced.

The resident's Urinary Incontinence and Indwelling Catheter CAA dated 3/28/14 included the resident was incontinent of urine due to diagnoses of schizophrenia and dementia.

The resident's Bladder Incontinence Evaluation dated 7/2/14 and timed 6:00 A.M. included the resident had an increase in the number of incontinent episodes, did not have a urinary tract infection and staff questioned if the resident had a change in behavior. The evaluation included staff toileted/prompted the resident every 2 hours.

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F 315	Continued From page 45 The evaluation lacked evidence as to what interventions the staff implemented to minimize the resident's increase in incontinent episodes. The resident's clinical record lacked evidence the facility performed a 3 day voiding assessment after the facility observed the resident had an increase in incontinence. The resident's temporary care plan dated 6/9/14 included staff toileted the resident every 2 hours. If the resident was incontinent of urine in the dining room the lobby or halls the resident lost his/her pop privileges the next day. The resident's care plan dated 7/3/14 included the resident had an alteration in elimination related to mixed urinary incontinence. Staff awakened the resident at regular intervals during the night to use the bathroom, the resident saw the urologist as scheduled and staff administered the resident's medications as the physician ordered. The resident wore an incontinent brief at night and the resident's incontinence bed pad was wet at times. Staff cued the resident to toilet every 2 hours during the day. The resident lost his/her pop privileges if he/she was incontinent in the lobby, the dining room, nurse's station, or hallway since it was a behavior unless the resident had a urinary tract infection. The resident's guardian would not take the resident out of the facility until he/she had no incontinence episodes for 2 weeks. The care plan included the resident refused to wear incontinence products during the day. The resident's care plan did not include the facility educated the resident or the resident's guardian on the advantages of wearing an incontinence	F 315		

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pad during the day.

The resident's 24 hour voiding diary dated 1/8/14 included the resident was incontinent of urine at 11:50 A.M. An entry titled conclusion, documented the resident remained dry if toileted every 2 hours.

The resident's 4/3/14 24 hour voiding diary included the resident was incontinent of urine at 2:00 P.M. An entry titled conclusion, documented the resident continued to have incontinent issues.

A nurse's note (NN) dated 6/22/13 and timed 11:30 A.M. included the resident had a urethral dilatation (procedure that stretched the urethra - the tube that allowed urine to pass out of the body) and staff received a physician's order to administer 2 doses of Keflex (an antibiotic) 500 milligrams.

A NN dated 6/22/13 and timed 11 P.M. to 7 A.M. shift included the resident was incontinent of urine during the night.

A NN dated 12/25/13 and timed 9:30 P.M. included the resident was occasionally incontinent of urine.

A NN dated 1/7/14 and timed 8:15 A.M. included the resident urinated on the dining room floor and staff assisted the resident to the bathroom.

A NN dated 1/8/13 and timed 1:10 P.M. included the resident was incontinent of urine in various places and the resident had his/her urethra dilated on 12/24/13.

A NN dated 6/26/14 (time unknown) included the resident urinated in the dining room after snacks

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and the resident would not receive a pop the rest of the day or evening.

On 7/22/14 at 9:30 A.M., 9:45 A.M., 9:50 A.M. and 10:00 A.M. the resident sat in a chair in the lobby area of the facility. At 10:10 A.M. 10:15 A.M. and 10:20 A.M. the resident received fluids during snack time in the dining room. At 10:30 A.M. the resident ambulated from the dining room to the lobby area of the facility and sat in a chair.

On 7/22/14 at 10:40 A.M. the resident ambulated independently to the bathroom. Observation revealed the resident did not wear an incontinent brief and was not incontinent of urine. During interview with the resident at that time, the resident stated staff did not prompt him/her to go to the bathroom, the resident toileted himself/herself.

Observation revealed no staff prompted/cued the resident to toilet after snack time.

On 7/22/14 at 1:20 P.M. the resident ambulated down the hallway and administrative nursing staff E stated the resident was going to the bathroom. Administrative nursing staff E sat at the nurse's station stated no one had prompted/cued the resident to go the bathroom. Administrative nursing staff E stated the resident knew when he/she needed to use the bathroom.

On 7/22/14 at 11:19 A.M. direct care staff O stated staff prompted/toileted the resident every 2 hours. Direct care staff O stated depending upon his/her workload he/she did not always prompt/toilet the resident every 2 hours. Direct care staff O stated he/she bathed the resident around 9 A.M., the resident was not incontinent of urine at that time and he/she had not prompt/toilet

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the resident since that time.

On 7/22/14 at 1:19 P.M. licensed nurse E stated the resident was incontinent of urine at times, staff reminded the resident to toilet after each meal, after snack times and anytime staff thought the resident sat for an extended period of time. Licensed nurse E stated since staff reminded the resident at the times mentioned above, the resident's incontinence was intentional. Licensed nurse E stated the resident was capable of going to the bathroom by himself/herself and without staff reminders to toilet. Licensed nurse E stated the facility performed a 24 hour voiding diary and not a 3 day voiding diary. Licensed nurse E stated the resident wore underwear without a pad during the day, and an incontinent brief at night. Licensed nurse E stated the resident did not like to wear a pad during the day.

On 7/22/14 at 3:55 P.M. administrative nursing staff D stated the resident was incontinent of urine at times. Administrative nursing staff D stated staff prompted the resident to toilet every 2 hours. Administrative nursing staff D stated when staff prompted the resident to toilet every 2 hours, the resident was less incontinent. Administrative nursing staff D stated when the resident was incontinent in the dining room, the lobby, or in the hallway the incontinence was a behavior and the resident lost his/her pop privileges. Administrative nursing staff confirmed the resident had a diagnosis of urinary incontinence and at times had his/her urethra dilated. Administrative nursing staff D stated the facility performed a 24 hour voiding diary versus a 3 day voiding diary. Administrative nursing staff D stated the resident wore underwear without a pad during the day and an incontinence brief at night.

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F 315	Continued From page 49 The facility failed to prompt the resident to toilet every 2 hours as planned and failed to develop an individualized toileting program for this resident who was frequently incontinent of urine.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 16 residents. Based upon observation, record review and interviews the facility failed to ensure 1 (#12) of 2 residents sampled for range of motion received appropriate treatment and services to increase range of motion and/or to prevent a further decrease in range of motion. Findings included: - Resident #12 quarterly Minimum Data Set (MDS) 3.0 dated 6/28/14 identified the resident scored 13 (cognition intact) on the Brief Interview for Mental Status, had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and other behavioral symptoms directed toward others. The resident was independent with bed mobility, transfers, walking in the room/corridor, and locomotion on the unit and required limited staff assistance with locomotion off the unit, and	F 318		

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personal hygiene and required staff supervision with dressing, eating and toilet use. The MDS identified the resident was unsteady but was able to stabilize without staff assistance while walking, turning around, moving from a seated to a standing position and the activity of surface to surface transfers did not occur. The MDS recorded the resident had an impairment on one side of his/her upper extremity and impairments on both sides of his/her lower extremities and did not use mobility devices. The MDS identified the resident had (1) no injury fall and (1) injury except major fall since the last assessment and did not receive restorative nursing services.

The resident's Activities of Daily Living (ADL) Functional Status/Rehabilitation Potential Care Area Assessment (CAA) dated 3/28/14 documented the resident was at risk for an ADL deficit due to diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and dementia (progressive mental disorder characterized by failing memory, confusion) and the resident's legs were unbalanced.

The resident's care plan dated 7/3/14 included the resident was at high risk for falls related to an impaired gait due to spastic movement and the use of psychotropic medications. The resident walked independently to his/her room and to the bathroom during the day, staff reminded the resident to use the hand rails as needed, staff accompanied the resident outside, staff reminded the resident to use the call light for stand by assist when out of bed and the resident may require assistance of 1 staff for ambulation with a gait belt if the resident's gait was unsteady.

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F 318	Continued From page 51 The resident's care plan did not include the resident received restorative nursing services. Review of the resident's nurses notes from 5/1/13 to 7/22/14 revealed the resident fell 6 times during the above time frame. A NN dated 2/3/14 and timed 12:45 P.M. documented on 1/31/14 at 1:00 P.M. the resident ambulated with assistance of 1 to 2 staff with a gait belt, and the resident had a slow, unsteady gait with a limp. On 7/21/14 at 9:40 A.M. observation revealed the group exercise in progress. Further observation revealed a resident led the exercise group, and the resident and 13 other residents in attendance. Observation revealed the resident attempted to perform the exercises with much difficulty. Observation revealed no staff cued/assisted the resident with the exercises. On 7/22/14 at 9:15 A.M. the resident ambulated independently to the nurse's station. Observation revealed the resident's gait was unsteady. On 7/22/14 at 9:50 A.M. observation revealed the group exercise in progress. Further observation revealed a resident led the exercise group, this resident and approximately 13 other residents were in attendance. Observation revealed this resident attempted to perform the exercises with much difficulty. Observation revealed no staff cued/assisted the resident with the exercises. On 7/22/14 at 9:15 A.M. the resident ambulated independently to the nurse's station. Observation revealed the resident's gait was unsteady. On 7/22/14 at 10:40 A.M. the resident ambulated	F 318		

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F 318	Continued From page 52 independently in the hallway. Observation revealed the resident's gait was unsteady. On 7/22/14 at 1:20 P.M. the resident ambulated independently in the hallway. Observation revealed the resident held onto the hand rails and the resident's gait was unsteady. On 7/21/14 at 3:54 P.M. direct care staff P stated the facility discontinued the resident's restorative nursing services a year or so ago and the resident currently did not receive restorative nursing services for the decrease in range of motion. On 7/22/14 at 1:19 P.M. licensed nurse E stated the resident attended the exercise group each day but did not receive restorative nursing services. On 7/22/14 at 3:55 P.M. administrative nursing staff D stated the resident's lower and upper extremities had functional limitation in range of motion and the resident attended the exercise group each day. Administrative nursing staff D stated a year or so ago evening shift staff assisted the resident with individualized exercises, the facility discontinued the exercises and the resident currently did not receive restorative nursing services. The facility failed to ensure this resident with a functional limitation in range of motion received restorative nursing services to maintain/improve his/her range of motion.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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	17E256	A. BUILDING _____ B. WING _____	07/24/2014

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as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This Requirement is not met as evidenced by:
The facility had a census of 34 residents. The sample included 16 residents. Based upon observation, record review and interviews the facility failed to provide timely and effective interventions to minimize falls for 1 (#12) of 1 residents sampled for accidents.

Findings included:

- Resident #12's quarterly Minimum Data Set (MDS) 3.0 dated 6/28/14 identified the resident scored 13 (cognition intact) on the Brief Interview for Mental Status, had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and other behavioral symptoms directed toward others. The resident was independent with bed mobility, transfers, walking in the room/corridor, and locomotion on the unit and required limited staff assistance with locomotion off the unit, and personal hygiene and staff supervision with dressing, eating and toilet use. The MDS identified the resident was unsteady but was able to stabilize without staff assistance while walking, turning around, and moving from a seated to a standing position, and the activity of surface to surface transfers did not occur. The MDS recorded the resident had an impairment on one side of his/her upper extremity and impairments on both sides of his/her lower extremities and did not use mobility devices. The MDS identified the resident had (1) no injury fall and (1) injury except

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F 323	Continued From page 54 major fall since the last assessment. The resident's Activities of Daily Living (ADL) Functional Status/Rehabilitation Potential Care Area Assessment (CAA) dated 3/28/14 documented the resident was at risk for a ADL deficit due to diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and dementia (progressive mental disorder characterized by failing memory, confusion) and the resident's legs were unbalanced. The resident's Fall CAA dated 3/28/14 included the resident was at risk for falls due to an unsteady gait and the use of psychotropic medications. The resident's Fall Risk Assessment dated 6/28/14 included the resident scored 5 (a score above 10 represented the resident was at a high risk for falls). The resident's temporary care plan dated 6/9/14 included staff assisted the resident with ambulation via a gait belt, used a personal safety alarm (PSA-a device which alerted staff the resident attempted to stand without staff assistance) and staff toileted the resident every 2 hours. Documentation included the facility discontinued staff assisted the resident with ambulation via a gait belt and the PSA on 6/25/14. The resident's care plan dated 7/3/14 included the resident was at high risk for falls related to an impaired gait due to spastic movement and the use of psychotropic medications. The resident walked independently to his/her room and to the	F 323		

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bathroom during the day, staff reminded the resident to use the hand rails as needed, staff accompanied the resident outside and staff reminded the resident to use the call light for stand by assist when out of bed. The resident may require the assistance of 1 staff for ambulation with a gait belt if the resident's gait was unsteady.

A nurse's note (NN) dated 7/30/13 and timed 7:25 A.M. included the resident walked across the lobby to the nurses' station to receive his/her medications, lost his/her balance, fell and landed on his/her hands and knees. Staff did not implement any new interventions.

A NN dated 10/12/13 and timed 2:00 P.M. documented the resident fell on 10/10/13.

The resident's clinical record lacked further documentation of the fall. No new interventions were implemented.

A NN dated 10/24/13 and timed 12:20 A.M. included the nurse responded to a call of assistance to go to the bathroom, the resident cried out, when stood at the bedside the resident cried out as he/she walked toward the bathroom. At the door of his/her room the resident pulled away, sped forward and fell to the floor. No new interventions were implemented.

A NN dated 1/24/14 and timed 10:00 A.M. documented the resident placed himself/herself on the floor by sliding out of the chair and onto the floor.

A NN dated 2/3/14 and timed 12:45 P.M. documented on 1/31/14 at 1:00 P.M. the resident ambulated with assistance of 1 to 2 staff

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members with a gait belt, the resident had a slow, unsteady gait with a limp.

A NN dated 2/25/14 and timed 9:30 P.M. documented the resident had a slow, guarded gait and used the hand rails to avoid falling.

A NN dated 6/3/14 and timed 1:30 P.M. included the resident had a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) on his/her left hip and the resident stated he/she fell in his/her room and did not report the fall to the staff.

A NN dated 6/10/14 and timed 2:15 P.M. documented the resident fell in the hallway on his/her right side and sustained a 2 centimeter (cm) hard area on his/her on hip. The resident's feet were tangled up which caused the resident to fall. Interventions included staff to assist the resident with ambulation.

A NN dated 6/11/14 and timed 1:40 A.M. documented 1 staff assisted the resident with ambulation, the resident had walked by himself/herself and staff reminded the resident to ask staff to assist him/her with ambulation.

A NN dated 7/8/14 and timed 7:45 A.M. documented the resident had an unwitnessed fall in front of the nurses' station. Interventions included new shoes with a thin sole and lighter weight.

On 7/16/14 at 2:41 P.M. observation revealed the resident's left knee was bruised. During interview the resident stated he/she fell and sustained the bruise.

On 7/17/14 at 10:49 A.M. observation revealed

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the resident's left knee was bruised.

On 7/22/14 at 9:15 A.M. the resident ambulated independently to the nurse's station. Observation revealed the resident's gait was unsteady.

On 7/22/14 at 10:40 A.M. the resident ambulated independently in the hallway. Observation revealed the resident's gait was unsteady.

On 7/22/14 at 1:20 P.M. the resident ambulated independently in the hallway. Observation revealed the resident held onto the hand rails and the resident's gait was unsteady.

On 7/21/14 at 3:54 P.M. direct care staff P stated the resident was at risk for falls, ambulated by himself/herself, staff use to assist the resident with ambulation using a gait belt but the facility discontinued it some time ago.

On 7/21/14 at 4:38 P.M. licensed nurse H stated the resident recently fell and sustained bruises on his/her knee.

On 7/22/14 at 11:19 A.M. direct care staff O stated the resident was at risk for falls if the resident did not pick up his/her feet. Direct care staff O stated until 2 to 3 weeks ago the resident had a PSA and staff ambulated with the resident via a gait belt.

On 7/22/14 at 1:19 P.M. licensed nurse E stated the resident was at risk for falls, the resident had new shoes which were lighter and better allowed the resident to pick his/her feet up off the floor, the resident held onto the hand rails and ambulated slowly. Licensed nurse E stated the facility discontinued the gait belt and PSA approximately a month ago because the resident

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F 323	Continued From page 58 kept getting up by himself/herself even after staff encouraged him/her to not get up without staff assistance. On 7/22/14 at 2:00 P.M. administrative nursing staff stated the facility did not keep fall investigations from the previous year; therefore he/she did not have evidence the facility investigated and implemented new interventions for the falls the resident had in 2013. On 7/22/14 at 3:55 P.M. administrative nursing staff D stated the resident was at risk for falls. The facility discontinued the PSA and staff ambulating the resident because the resident kept getting up without staff assistance. Administrative nursing staff D stated the resident got new shoes after the last fall which assisted the resident to pick up his/her feet. The facility failed to develop timely and effective interventions for this resident with a history of falls.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		

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F 441	Continued From page 59 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility reported a census of 34 residents. The sample was 16. Based on observation, record review, and interview the facility failed to provide resident #35 (identified as a roommate of another resident with head lice) treatment for head lice. Finding's included: - Resident #35's roommate was identified with head lice on 3/18/14. The quarterly MDS dated 5/14/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. He/she was independent with bed	F 441		

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mobility, transfers, walking in room/corridor, locomotion on the unit, dressing, and toilet use. He/she required supervision for personal hygiene, eating, and locomotion off of the unit.

The care plan dated 8/7/14 revealed the resident had poor judgement and impaired thoughts.

Record review of the physician's orders from 3/18/14 to 7/22/14 revealed no order for treatment of head lice.

Review of the Medication Administration Reviews (MARs) and Treatment Administration Reviews (TARs) from 3/18/14 to 7/22/14 revealed no documentation of treatment for head lice.

Review of the nurses notes from 3/18/14 to 7/22/14 revealed no documentation about head lice or treatment of head lice. The medical record failed to support treatments he/she received.

Record review of the facility infection control log provided by administrative nursing staff D, from January 2014 through March 2014, revealed resident #35 did not have lice due to his/her coarse hair.

Record review of the lice care plan for the residents roommate, dated 3/18/14, documented the resident was not treated for lice because of his/her hair type, had coarse textured hair, and staff could not see anything in his/her hair. On 3/25/14 the staff checked the resident and he/she did not have lice.

Observation of the resident on 7/22/14 at 10:20 A.M. revealed the resident sat in a chair by the outside door, smiling, and in a pleasant mood.

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F 441	Continued From page 61 During an interview with the resident on 7/22/14 at 3:14 P.M. he/she stated he/she was never treated for lice at the facility but he/she did have lice as a child and was treated for that. During an interview with Housekeeping/maintenance staff X on 7/21/14 at 2:30 P.M. revealed he/she cleaned the rooms of residents treated for lice with bleach. He/she stated everything was bagged up and taken away. He/she stated he/she did not remember how many days things got bagged up but it was done. He/she stated he/she used spray that was supposed to kill everything but did not know the name of the spray. During an interview on 7/22/14 at 9:40 A.M. with administrative nursing staff E stated staff D took care of the lice and documented it. He/she stated staff D checked everyone's head and treated those who needed treatment. During an interview with administrative nursing staff D on 7/22/14 at 9:48 A.M. revealed there was no documentation of head lice. He/she stated kept his/her own records of it. He/she stated he/she documented whether or not he/she removed nits and when he/she rechecked the residents. He/she stated the residents' room and roommates' were treated. He/she stated staff did not treat resident #35 because his/her race did not get head lice, he/she stated "they just {do not} have the texture of hair". On 7/22/14 at 11:18 A.M. staff D stated he/she had no documentation or resource for not treating resident #35, he/she stated it was his/her knowledge he/she went by for not treating the resident.	F 441		

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F 441	Continued From page 62 On 7/22/14 at 11:47 P.M. staff D stated, we did not get an order for the treatment of lice or for not treating resident #35, I did not get an order for treating resident #35 because of his/her race. We know how to treat lice so we did not get an order. During an interview on 7/22/14 at 12:18 P.M. with administrative nursing staff E stated there was no order in the MAR or TAR for the treatment of lice. He/she stated it was not treated by the nurses. During an interview on 7/22/14 at 4:13 P.M. with administrative staff A stated was no order for the lice treatment because it could be bought over the counter. He/she stated he/she felt comfortable treating it in the facility. Administrative nursing staff A stated staff D used to be a school nurse and could identify the need to treat head lice or not. Staff A stated the resident was not treated because staff D stated he/she knew from school experiences certain races had a lower percentage of getting head lice than others. He/she stated the facility did not have any policy or form that showed why the resident should not be treated. The facility provided a policy for treatment of head lice, not dated, documented the residents in the same room with the infested resident would also be treated with the lice shampoo and staff would reexamined in 1 week. Staff thoroughly clean the resident's room with a bleach solution and other residents were not permitted to enter the infected room. The facility failed to treat this resident for head lice.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465		

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F 465	Continued From page 63 E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This Requirement is not met as evidenced by: The facility reported a census of 34 residents. The sample included 16 residents. Based on observation, and interview, the facility failed to provide a safe external environment and maintain the buildings exterior for 3 of 4 days on site of the survey. Finding's included: - During the environmental tour on 7/22/14 at 7:45 A.M. revealed: The outside of the facility had bugs and dirt in the air conditioning unit and light fixtures. The outside of the building revealed wood rot and peeling paint on the boards. The front of the building revealed a metal swing with 2 plum sized holes. Maintenance staff X reported he/she cleaned the light fixtures 2-3 times a month but did not know who cleaned the air conditioner. He/she stated the building was old and would have some wear and tear. He/she stated the metal swing usually had a cushion cover on it and did not know how or when the holes appeared in the swing. During an interview on 7/22/14 at 7:45 A.M. with housekeeping/maintenance staff X he/she reported there were no logs, or routine maintenance program. He/she stated items were placed on a list for repairs and he/she got to it when he/she could. The list was written but the	F 465		

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F 465	Continued From page 64 list was not kept. On 7/22/14 at 4:13 P.M. administrative staff A reported the facility runs a list for environmental tasks and once the tasks were completed they threw away the lists. He/she stated everything got fixed as quickly as possible, and the swing with the holes in it was immediately thrown out after maintenance staff X saw it on the environmental tour. He/she stated it was not reported. The facility failed to provide maintenance services to maintain the exterior of the facility.	F 465		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		

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F 520	Continued From page 65 This Requirement is not met as evidenced by: The facility identified a census of 34 residents. Based on interview and record review, the medical director did not attend the quarterly Quality Assessment and Assurance (QAA) meetings. Findings included: - Interview on 7/22/14 at 4:55 P.M. administrative nursing staff D stated the facility had no evidence of who attended the quarterly QAA meetings. The same 5 people always attended. The facility's physician signed all the minutes, but he/she only attended the second and the fourth quarterly meetings. Staff D stated there was never a sign in sheet for the QAA meeting in the past four years he/she worked at the facility. He/she stated administrative staff A, administrative staff D, social services HH, and the facility doctor routinely attended the QAA meetings. The medical director failed to attend the quarterly QAA meetings.	F 520		